Towards a Coordinated School Health Program in the District of Columbia: A Status Report on School-based Health Care and Proposals for Reform

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This document formulates a plan for the coordinated delivery of health services in the District of Columbia public schools and public charter schools. On October 26, 2005, the Chairman of the Council of the District of Columbia Committee on Health, Mr. David Catania, charged the Department of Health (DOH) and other city government agencies to produce a plan for a coordinated school-based health service program by January 2006. Since then, in order to fulfill the task, DOH has consulted with a broad range of participants including city government agency and community experts. We also reviewed relevant reports, scientific articles, and other documents to appraise the current status of school-based health service programs and to explore effective and promising practices in the delivery of such services.

In addition to providing a status report, this document proposes strategies and associated timelines to improve current school-based health service arrangements (Section IV). A summary of the timeline and proposed measures is presented below. The strategies are based on extensive consultation with expert and community groups and count with the support of a variety of community-based stakeholders and government agencies involved in this effort. Appendix 1 contains a list of individuals and organizations that commented or otherwise contributed to this report. Their views are gratefully acknowledged but their interpretation and the content of this document are the sole responsibility of DOH.

We have attempted to discuss the pros and cons of the various options for reform with concerned parties and remain committed to jointly finding solutions to issues that may remain unresolved or that may arise during plan implementation. The goal of DOH is to develop a desirable and doable plan that will be supported by parents and students, the Council of the District of Columbia, the office of the Mayor, local boards of education, public charter school administrators, and city agencies like the public school administration (DCPS) and the Department of Mental Health (DMH) with firm commitments for implementation from all involved.

School Health Services Plan Timeline

Timeline	Program coordination and accountability	Facilities and information infrastructure	Service coordination and quality of care	Budget and funding
At plan submission (Day 1: January 30, 2006)	▪ Appraised existing school-based health services and solicited comments from DCPS, DMH, community-based organizations, providers and others on the draft status report and proposed plan ▪ Solicited input from DCPS, Charter schools and others to develop new scope of work for school health nursing program	▪ Selected proposed facility standards for health suites ▪ Selected proposed facility standards for SBHCs ▪ Obtained assessment of the condition of health suites based on accepted standards	▪ Explored integration of school nurses into Student Support Services Team (SST), a recently established multidisciplinary team in each school to assess individual student needs ▪ Obtained proposal for alternative staffing model for school nurse program ▪ Selected proposed core service, staffing and other standards for SBHCs	▪ Estimated cost of providing full time nursing service coverage for all schools (including LPNs) ▪ Estimated cost of bringing health suites into compliance with standards ▪ Estimated cost of providing current services at SBHCs
By the first month (February 28, 2006)	▪ Review all existing MOUs signed by DCPS for the provision of health care in schools ▪ Develop the scope of work to be included in the new RFP for the school nursing program	▪ Adopt standards for health suite accommodations based on the National Association of School Nurses ▪ Explore with DOH/HRLA feasibility and authority to inspect and certify compliance with standards for health suites and other school-based facilities ▪ Constitute a multidisciplinary school health IT project team	▪ Ensure that nurses participate in the student Support Services Team (SST) at each school ▪ Ensure that school nurses participate in the Multi- Disciplinary Team (MDT) responsible for developing an individualized education plan (IEP) at each school. ▪ Develop policy that a) a copy of any individual health record (IHP) available at the school is securely maintained in the health suite; b) all medically fragile children have an IHP on file. Develop procedures for: referral, communication with medical home provider	▪ Explore temporary reimbursement arrangements between Medicaid health plans and SBHC for covered services ▪ Develop a financial statement with all funding allocated by individual city government agencies to clinical services.

Timeline	Program coordination and accountability	Facilities and information infrastructure	Service coordination and quality of care	Budget and funding
By the third month (April 30, 2006)	▪ DOH convenes a "town hall meeting" or "listening session" to include and obtain the views of parents, students and concerned citizens on the school health plan ▪ Develop a draft master MOU that specifies governance and accountability structure for school health care services, agency roles and responsibilities (DCPS,DOH, DMH, etc.) ▪ Complete consultation with experts and advocates (including those involved in the Medical Homes DC project) and reach consensus on one or more clinical and financially viable models for health centers for the District (school-linked, school-based model, or both) ▪ Establish a School Health Service executive committee of senior representatives from DOH, DCPS, DMH and other involved agencies ▪ Adopt a student bill of rights ▪ DCPS convenes panel to review content of HIV/STD/teen pregnancy prevention curriculum supplement integration	▪ In conjunction with DCPS develop an improvement plan for all health service facilities.	▪ Develop a uniform IHP form or template for use in all schools ▪ Explore adoption of the standard medical record form for EPSDT evaluations ▪ Review status of school oral services and explore possibilities for expansion ▪ Adopt policy statement defining the "medically fragile student" in the school population ▪ Develop and distribute a system-wide brochure that provides an introduction to the school health nursing program and includes information about what nurses do, when it is appropriate to go to the health suite, how emergencies are handled, and other relevant information about the program. ▪ Conduct a revision of nursing staffing models and practices with CNMC	▪ Define sources of funding and seek resources to bring school nursing suites, counseling offices and SBHCs up to standards. ▪ Explore potential contractual or other reimbursement arrangements between school-based practitioners and health plans. ▪ Develop feasibility study and potential design of a unified billing system for all school-based practitioners providing third-party reimbursable services ▪ Identify funding to contract for a study to evaluate nursing services and develop remaining components of a comprehensive school health program (e.g., nutrition, environment) ▪ Develop funding mechanisms to provide the number of hours stipulated by law to all public and charter schools in the District. Streamline process to fund "supplemental" nursing coverage in selected schools in consultation with DCPS. ▪ Seek funding to provide full time nursing coverage through alternative staffing models (e.g. use of LPNs to supplement RN coverage)

Timeline	Program coordination and accountability	Facilities and information infrastructure	Service coordination and quality of care	Budget and funding
By the sixth month (July 31, 2006)	▪ Complete and sign master MOU between DCPS, DOH, DMH and any other involved agencies ▪ DCPS and partner agencies develop a district level wellness policy that addresses physical activity and nutrition for implementation in SY 2006-07 ▪ Charter and establish a school health service advisory committee staffed by DOH/DCPS ▪ DOH drafts policy statement specifying approval process for establishing SBHCs or SLHCs based on geographic need and sets guidelines/standards for school health center operations ▪ Issue guidelines/standards regarding scope of service, facility and other requirements for the nursing program ▪ Let contract with expert outside entity to evaluate nursing program	▪ Establish Internet connectivity (e.g., installing equipment) for health suites that do not require major facility renovation ▪ The IT project team will complete a feasibility study on implementation of shared electronic health record system for the schools	▪ Establish minimal standards of care for all school-based health services (nursing, mental health, SBHC) ▪ Establish performance and outcome measures, and continuous quality improvement procedures for school health services.	▪ Complete study of financial models supporting SBHCs or SLHCs in other jurisdictions ▪ Develop FY 2008 budget request that includes school health service funding for 2nd year of plan implementation

Timeline	Program coordination and accountability	Facilities and information infrastructure	Service coordination and quality of care	Budget and funding
By the 9th month (October 30, 2006)	▪ Draft policy statement specifying approval process for establishing SBHCs or SLHCs based on geographic need ▪ DCPS convenes standards roundtable to develop health education curriculum	▪ Develop a secure, HIPAA compliant system of collecting, maintaining, sharing and reporting student health data.	▪	▪
By the 12th month (January 31, 2007)	▪ Complete evaluation of school nurse services and determine next implementation steps ▪ Propose language for any regulatory change required to further the reform of school nursing, mental health and SBHC services	▪ Complete development and implementation of new IT software systems and training of nurses and other appropriate school health staff	▪ In collaboration with DOH/MAA and other members of the District of Columbia Partnership to Improve Children's Healthcare Quality (DC PICHQ) explore implementation of a secure electronic shared record registry for EPSDT data on all District children.	▪ Finalize billing and reimbursement arrangements between Medicaid health plans and current SBHCs.

Scope of the Report

This document centers primarily on the coordinated and sustainable provision of health care services for the general population of students within the public schools in the District of Columbia.[1] Although we exclude an analysis of issues specifically related to children with disabilities and those requiring special education, we do discuss medically fragile children to the extent that this population also may heavily utilize services available to all students and thus affect health service capacity in each school (e.g., the number of hours of nursing services required).[2]

By focusing only on services for the general school-age student population, the proposal addresses a basic component of a *comprehensive* school health program for the District of Columbia. According to a model proposed by the Centers for Disease Control and Prevention (CDC), a comprehensive school health program should fully integrate "the efforts and resources of education, health and social service agencies to provide a set of activities and services to promote health and prevent chronic diseases and their risk factors among young people."[3]

Key among these activities is the development of a health education curriculum. The health of young people (and the adults they will become) is linked to habits that are often established during youth and can be influenced through education. These habits contribute to today's major causes of death and morbidity (e.g., heart disease, diabetes, cancer.) Behaviors include using tobacco, alcohol and illicit drugs, overeating, neglecting physical activity, and engaging in premature or unprotected

[1] Throughout this document we assign distinct meaning to the terms "coordinated" and "comprehensive" (which are *not* used interchangeably.) As we discuss more in detail in the text, we focus here on the coordination of school-based health care (i.e., nursing program, health center, and mental health practitioner services.) Reasonably well coordinated health care is merely a component, albeit a critical one, of a comprehensive school-based program (which would also involve other school-based activities such as nutrition services, physical education, a health education curriculum, etc.)

[2] Medically fragile children include those with chronic conditions such as moderate or severe asthma. Childhood asthma poses a particular concern in urban settings where prevalence, hospitalization and mortality rates for this condition are higher than in non-urban settings. In spite of this higher prevalence, research evidence suggests that inner city children may be inadequately diagnosed and treated for asthma and that prevention and educational interventions have been underused. See N Lurie, et al. Asthma Outcomes at an Inner City School-based Health Center. *Journal of School Health.* January 2001.

[3] C Fisher, Pet Hunt et al. "Building a healthier future through school health programs." In Centers for Disease Control and Prevention (CDC): *Promising Practices in Chronic Disease Prevention and Control: A Public Health Framework for Action.* 2003.

sexual activity (which increases the risk for sexually transmitted diseases and unintended pregnancies). Health education in schools can reduce the prevalence of such habits that put the health status of children and adolescents at risk. Students need to acquire health and health care-related knowledge and skills early and throughout their educational experience. The curriculum should be evidence-based and scientifically sound. It should be implemented consistently across all grades and in all schools and should be updated as new scientific information becomes available.[4]

In addition to health services and health education, a comprehensive health program in the District of Columbia would include the following five components: 1) a health-enhancing physical and social school environment; 2) nutrition services; 3) physical education and activities; 4) health programs for faculty and staff; and 5) collaboration among schools, families and communities to improve the health of students, faculty and staff. Although DOH has focused its initial efforts on reviewing primarily school-based health care services for the general school population, these other school health components could be gradually integrated at a later date into the core health service architecture proposed here.

Similarly, the specialized system of health services for disabled children under the Individuals with Disabilities Education Act (IDEA) constitutes another key component of any comprehensive school health plan. However, an adequate treatment of this complex area is beyond the scope of the present work. As mentioned above, DOH considers this proposal the beginning of an ongoing effort to improve our school health program. We expect that the health and education agencies that share the goal of protecting the well being of young people and have come together for this task will continue to collaborate throughout plan implementation. A governing structure (including a planning process) that brings together key resources, programs and decision makers from DCPS, public charter schools, DOH and other interested city agencies would cement this collaboration. Such a structure is critical to sustain improvement and advance further reform efforts including those related to special-education services.

[4] Appendix 2 describes key health curriculum-related activities DCPS has undertaken. January 2006. We anticipate that DOH will continue to collaborate with DCPS as the health education standards are developed.

In sum, this report submitted to the Council primarily focuses on health and healthcare services provided by nurses, school-based center staff, and other clinicians to the general school population. It specifically addresses the staffing of and coordination among nursing, school-based health center, and mental health services, as well as the linkage between these school-based services and the larger community health care system. It also looks at the facility requirements, funding, chain of accountability, and other key features of a school health care system.

The first section of this document provides a brief description of the health services offered in schools. Section II of this document lists a variety of concerns that have been raised in the course of our inquiry with respect to current service arrangements. Section III addresses the key topic of program coordination and accountability and discusses options for reform of nursing and school health center services in light of the experience of other jurisdictions. In section IV we propose specific strategies applicable to the District and estimate timelines for their implementation. In the last section, we address specific questions the joint Committees posed to the Department of Health during the last hearing on school health conducted on October 26, 2005. The appendices contain more detailed information about a variety of topics discussed throughout the text.

The plan document starts to address questions unanswered to date that are basic to the development of a coordinated school-based health care system in our city: What health services are undertaken in schools; who furnishes them; who or what organization(s) should control the resulting system of care and be accountable for its performance. This proposal also starts to tackle the perennial questions: How much do these services cost and how should we pay for them.

I. Background

Unresolved health and mental health problems constitute one of the most common obstacles faced by children who have difficulty succeeding in school. There is a direct correlation between a child's health status and his or her ability to achieve academic success. For instance, studies of students who drop out of school show that

the majority do not finish high school because of health-related problems. Also, as the socioeconomic status of students decreases, the prevalence of health-related problems increases. Low socioeconomic status and the inability to afford preventive medical care, and to access health care services all affect the student's capacity to focus on schoolwork. [5]

Decision-makers in health care and in education are trying to raise student achievement and well being in the District of Columbia public school system. But child poverty, high rates of substance abuse, sexually transmitted disease and teen age pregnancy, depression and other conditions often coupled with the stress of broken homes burden students in a number of areas of the District. The Administration, the City Council and civic groups are looking at these health-related causes of student failure and have expressed the intent to firmly address them.

One response that has sprung across the nation in recent years to tackle these issues predominantly affecting teenagers stems from a simple intuition: "Put the health care where the kids are." In addition to the traditional provision of school nurse services, communities have been opening health centers in schools (in poor neighborhoods in particular). Local hospitals, community health centers, and occasionally public health departments run ***school-based health centers*** (SBHCs), which have rapidly increased in number over the last decade.[6]

Although the health centers emphasize prevention and early intervention much like school nurses have done for many generations, SBHCs also deliver comprehensive primary care – a "medical home." The staff includes nurses but also nurse practitioners, mental health providers, and aides. Part-time pediatricians and other clinicians (such as dentists and child psychologists or psychiatrists) expert in adolescent and child health may also be on staff. The combined team can identify and treat the most common presenting health disorders without the need to make referrals or arrange transportation. They conduct comprehensive well child exams, diagnose and treat injuries, STDs and chronic conditions such as asthma, as well as mental

[5] ROW Sciences. *District of Columbia School Health Initiative Needs Assessment*. Final report prepared for the (former) Office of Maternal and Child Health, DOH. June 2001.Available from DOH (Maternal and Family Health Administration) upon request.
[6] James Morone et al. "Back to school: A health care strategy for youth." *Health Affairs*. January 2001.

health problems. (Although the scope of services allowed and parental consent policies may vary widely from one locality to another). Ideally, these clinicians also educate parents, consult with teachers, and teach students about anger management, nutrition, and risky sexual practices.[7] Health centers also tend to have access to established referral networks through their sponsoring health care organizations. Ultimately, these centers offer access to comprehensive services for children who are not obtaining health care elsewhere.

In the District of Columbia, DOH and community-based health care organizations currently operate SBHCs in one elementary and two senior high school settings. These are Brightwood Elementary School, Eastern Senior High School, and Woodson Senior High School. These SBHCs are operated by Mary's Center for Maternal Child Care, Unity Health Care, and the DOH respectively. Another health care organization, the Community of Hope, operates a health center adjacent to the Marie Reed elementary school, which is typically considered a school-linked health care center (SLHC) rather than a SBHC.[8] Additionally, Georgetown University Hospital provides school-linked care at Spingarn and Anacostia Senior High Schools through its mobile medical clinic, which can also provide comprehensive services.

Nationwide, however, the most common health care providers to furnish school health services continue to be ***school nurses***.[9] Models for the delivery of school nursing as well as the role of school nurses vary among district schools. The balance between community health concerns and personal health services also differs. Some jurisdictions have attempted to standardize the services school nurses are expected to provide. For instance, the state of Colorado has issued guidelines defining

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[7] *Ibid.*

[8] A *school-based* student health center has been defined as "a health center located in a school or on school grounds that provides, at a minimum, on site primary and preventive health care, mental health counseling, health promotion, referral and follow-up services for young people enrolled." On the other hand, a *school-linked* student health center is a health center that is located beyond school property that provides similar services to one or more schools. Such center may also serve young people from the area who are not students, and may have formal or informal ties to the school.

[9] E Scheinker et al. "School nursing services: Use in an urban public school system." *Archives of Pediatric and Adolescent Medicine.* January 2005. School counselors constitute another mayor component of school support service staff. Counselors frequently are responsible primarily for academic guidance. This school-hired mental health professional staff typically dedicates a substantial amount of time to assessment and care of students eligible for federally-required services (e.g., special education students). A full discussion of the role and significance of school counselors is beyond the scope of this document.

"essential" school health nursing services in the areas below (as well as a tool or checklist for individual districts to evaluate their adequacy locally):

- Coordinate mandated health services in the educational environment
- Prevent the spread of disease
- Protect against environmental hazards
- Prevent illness and injury
- Promote healthy behaviors
- Ensure the quality and accessibility of health services
- Respond to disasters
- Collect, interpret and evaluate data [10]

School nurses at a minimum perform required health screenings, administer medication, provide first aid treatment, and manage the care of students with chronic medical conditions. In the District of Columbia, the law requires that a registered nurse (RN) be assigned to each public school to perform these duties for a minimum of 20 hours a week.[11] In October 2000 the mandate for provision of nursing services was extended to DC Public Charter Schools as well.[12] Such services are currently provided in 150 DCPS schools (with approximately 62,000 students as of October 2005) along with 20 public charter school sites (with roughly 7,000 students).[13] The current staffing model includes about 120 full-time equivalent (FTE) staff and contract RNs. The more than 30 remaining charter schools have no publicly funded nurses at present.

Children's National Medical Center (CNMC) administers school health nursing services to both DCPS and Public Charter Schools since 2001 under contract

[10] See appendix 3 for a full list of activities. Colorado Department of Education. *Essential School Health Services Guidelines.* 1999. See also American Academy of Pediatrics: The role of the School Nurse in Providing School Health Services. *Pediatrics*. November 2001.
[11] DC Law 7-45: School Nurse Assignment Act. 1987. The DC public schools that received more than 20 hours of nursing services at the time of the passage of the law received full-time (40 hour) coverage.
[12] Charter schools are independently-operated public schools that are open to all District residents. Public Charter Schools receive public funds based on the number of students they enroll, as do all District of Columbia public schools. The D.C. Board of Education and the D.C. Public Charter School Board are the two chartering authorities in the District. Each authority can approve up to ten charter school applications per year. Approximately 24% of children enrolled in public schools in the District are estimated to attend charter schools.
[13] DCPS and Public Charter Boards. FY2005-06 Official Membership, DCPS, October 2005.

with DOH. Nursing services identified in the original contractual agreement include: "review of immunization status, basic health screenings, and comprehensive education and prevention programs for smoking, nutrition, pregnancy, HIV/AIDS, substance abuse and mental illness (…) School health nurses are also responsible for implementing effective referrals into the larger health care system when a health need is identified."[14]

DOH and CNMC have entered into a separate, annually renewed agreement for the provision of nursing and other services (e.g., oral health, physician services) for children with special health care needs enrolled in four special education schools. This contract also provides for nursing services in two public and two charter schools.[15] Finally, through a memorandum of understanding (MOU) with DOH, DCPS funds a third agreement with CNMC for the provision of supplemental nursing services beyond the required minimum of 20 hours for certain public and charter schools. This agreement is also renewed on an annual basis depending on the available budget put forth by DCPS. Current funding from all sources for the 2005-2006 school year is $13, 242, 225 (of which DCPS contributed $1,366,400). DOH plans to issue a request for proposal to consolidate these three instruments into a single contract in place for the provision of all school nursing services during the 2006-2007 school year.

Finally, the Department of Mental Health (DMH) has entered into an agreement with DCPS to provide ***school-based mental health services*** to the general student population and their families in certain public and charter schools. Behavioral health (including substance abuse and mental health) difficulties constitute a significant proportion of all referrals to nursing and SBHC services. At present, the School Mental Health program (SMHP) run by DMH staff offers an array of need-based mental health services including prevention, early intervention, focused assessments, brief treatments, consultation, and crisis response in 20 DC public schools and 10 charter schools. A thorough evaluation has recently shown the

[14] The School Health Nurses Program was transferred from the District of Columbia Health and Hospitals Public Benefit Corporation (PBC) to CNMC during the 2001 – 2002 school year. Exhibit A, Section 6, *DC HealthCare Alliance Master Agreement, Contract Modification #2*. June 2001.
[15] Letter of Contract. Contract No. POHC-2005-C-004 between the Department of Health, Health Care Safety Net Administration and Children's National Medical Center. 2005.

effectiveness of this program in improving outcomes for the targeted population. Plans for the expansion of this well regarded program are underway.[16]

II. Current School Health Care Service Arrangements: Status Report

Since the hearing on October 26, 2005, Maternal and Family Health Administration (MFHA) staff have consulted with experts and reviewed school health literature to gather advice and recommendations for improving the provision of school-based health care in the District of Columbia. We reviewed a survey of the health suites located in DC public and public charter schools conducted by CNMC, the primary contractor providing nursing services, to determine the baseline status of the facility and equipment needs for the school nursing program. To complete our appraisal of the status of school health services we also visited SBHCs, reviewed facility, staffing and other widely accepted school health standards, and produced preliminary cost estimates for certain proposed measures.

Assigned with the task to explore stable sources of funding, we have also looked into the feasibility of obtaining Medicaid reimbursement for nursing and other services including those provided by school-based health centers. We consulted with our counterparts in New York State to learn about their experience with the regulatory and approval process for SBHCs as well as their experience with Medicaid reimbursement for services provided at these centers.

The following is a listing and brief description of the gaps and concerns we have identified related to current program arrangements that affect the delivery of health services to the school-age population. Identification and understanding of these and other issues is a pre-requisite to facilitate the dialogue among stakeholders to overcome these difficulties and jointly create opportunities for system-wide health service improvement.

[16] D. C. Department of Mental Health: *School Mental Health Program Progress Report: 2000-2005.* Appendix 4 contains a summary description of SMHP. Also included is a needs assessment survey DMH staff carries out periodically. The survey instrument illustrates some of the issues the program seeks to address in both public and public charter schools.

We do not intend to be critical of the dedicated, compassionate, and competent caregivers, contractors, school administrators and other stakeholders who, as a whole, make a strong programmatic and financial commitment to the children of the District. Our purpose is to bring forth information to assist the various programs evolve operationally and continually improve their effectiveness.

Nursing services

- The school nursing program is currently staffed almost exclusively with registered nurses. The interpretation of the legal mandate that a registered nurse provide at least 20 hours of service per week in every school may need to be revised as it is currently implemented. Concerns relate first, to the partial nature of the required coverage (i.e., 20 hours of nursing services). This is of particular importance in schools where the student body has a heavy burden of chronic conditions such as asthma or diabetes or includes a significant number of medically fragile children. Such a student configuration would call for full-time nursing coverage during normal school hours. By providing partial coverage of nursing services (limited to RNs), the city is potentially exposed to considerable risk if an emergency occurs at a time when no nurse is available

  Second, a staffing model predicated on the premise that an RN must be present at each school is not necessarily based on the needs of individual students and the size of the student population. Unlike other health care systems, the current staffing model does not have the ability to adjust personnel to service demand or need. Demand for services depends in part on the number of children in the school, and the proportion of students deemed medically fragile and in need for ongoing monitoring or more labor-intensive care. With respect to the number of students, the National Association of School Nurses (NASN) recommends the presence of one FTE nurse for every 750 students.[17] Some District high schools have a higher ratio of students to FTE nurse than the standard. Such level of

[17] The NASN also recommends a school nurse-to-student ratio of 1:225 when special needs students are mainstreamed in conventional settings, and of 1:125 when the overall school population is severely, chronically ill or developmentally disabled. NASN Position statements: "Caseload Assignments." http://www.nasn.org/Default.aspx?tabid=209 accessed on January 17, 2006

service may not be sufficient to meet the health care needs of the student population in those schools. Conversely, small elementary schools with a couple of hundred students and few medically fragile children may have a full-time nurse. Presumably, more than one such school could effectively share the services of a single RN, particularly if the school sites are on the same campus or close to each other.

Finally, much of what nurses perform during a typical school day does not require the level of a registered nurse. Licensed practical nurses (LPNs) and other assistive personnel could generate letters, dispense medication, track down parents, and provide certain levels of care under the supervision of a registered nurse which are all activities within their scope of practice. The current staffing model based almost exclusively on RNs does not allow the flexibility to match the skills of caregivers with student needs. Although the authorizing statute prefers RNs, the law appears to allow the use of LPNs working under an RN to a much larger extent than presently utilized.

- Over the last few years DCPS has placed a larger proportion of medically fragile children in "mainstream" schools than in the past.[18] The influx of these students with special health care needs in certain schools affects the nurse's ability to adequately attend to the general student population. These children may not need special education services (e.g., speech therapy) due to cognitive delays or difficulties but experience medical conditions that call for the use of health care technologies (such as feeding tubes, ventilators, ostomies, or orthopedic devices) to thrive and even stay alive. These medically fragile students require careful monitoring and extra attention on the part of school-based health care personnel.

[18] *Medically fragile students* are those with healthcare needs that require specialized health technologies or procedures for life support or health support during the school day. These students may not require special education. Medically fragile children have also been described as persons with complex medical care needs who require technology, specific services, or some form of ongoing medical or nursing support for survival. These students face daily the possibility of a life-threatening emergency requiring the skill and judgment of a professional nurse. American Federation of Teachers. *The Medically Fragile Child in the School Setting*. 2nd ed. Washington, D.C. 1997. Please see Appendix 5 for a more detailed discussion of issues and strategies related to the mainstreaming of medically fragile students prepared by CNMC.

However, system-wide policies and procedures are not in place to a) alert the contractor administering nursing services about the expected case load of medically fragile children in a given school or b) involve the nurse in the initial planning and coordination of care for these students or c) ensure that a copy of the updated individualized health plan (IHP) is maintained in the health suite or otherwise readily available to the school nurse. As indicated earlier, the current staffing model based on assigning an RN to each school regardless of student population number or characteristics does not allow much room for adjustment to variable service demand.[19]

- The majority of public charter schools in the District do not currently receive the minimum of 20 hours of nursing services stipulated by law. Although the statute makes funding contingent on available appropriations, the fairness of public fund allocation is in question when some public schools have full time coverage and other have none.

- Observers have also raised concerns over the adequacy of current arrangements to address emergencies medically fragile children may present: How are DCPS, DOH and CNMC ensuring that nursing personnel have the training and ability to provide appropriate health assessments? Are there procedures in place to communicate with the child's parent or guardian and to provide emergency care in a timely manner? Have individual health plans been developed for all medically fragile children? In addition to constituting a concern with respect to the quality of care provided in schools, inadequate or poorly implemented policies and procedures to protect the health of this vulnerable student population put the institutions responsible at risk for liability, as a recent lawsuit involving the death of a student shows.[20]

- The use of prescription drugs has increased in recent years for the overall student population. Administering medication in a reliable and safe fashion is reportedly

[19] See appendix 6a for a more detailed discussion of alternative staffing models for the nursing program and associated cost estimates.
[20] Theola Labbe. "Missteps cited in girl's death: Sick, disabled student was put on D.C. school bus." *Washington Post.* August 18, 2004.

an unresolved issue particularly in schools that do not have trained health professionals on site on a full-time basis.

- CNMC hires a significant proportion of contract personnel to staff its program with registered nurses. The fact that these practitioners are not employed by CNMC may affect continuity of care and adds complexity to program management and contract oversight. For instance, the capacity to provide for an adequate nurse "float" pool of nurses to cover schools when assigned nurses are absent is limited. Some other jurisdictions utilize personnel such as licensed practical nurses under the supervision of registered nurses to provide aid for minor injuries, administer medications, and perform administrative duties, thus freeing up school nurse time for clinical work.

- Many parents, teachers and students do not know what nurses do and do not do, how emergencies are handled in schools, and other important information about the nursing program.[21] Parents do not always understand the requirements to periodically submit health and dental certificates or even know that the program is managed by CNMC.

School-based and school-linked health centers

- Community advocates and experts consulted agreed that the creation of additional SBHCs or the development of stronger linkages with community-based health care providers such as community health centers would enhance access to services for the student-age population living in underserved areas of the city. The various groups consulted could probably find consensus fairly readily on defining the areas of most need where capacity expansion would be most beneficial. Some observers suggested that expansion of SBHCs or SLHCs should be considered in the context of the Medical Homes DC initiative.

[21] CNMC has made available to DOH a document containing key aspects of an expanded nursing program which addresses not only nursing direct care services but other components of a comprehensive school health system as well. Appendix 7 contains the mission, goals, and scope of comprehensive nursing services to be potentially provided under a new contract with DOH.

However, advocacy groups are not yet of one mind with respect to which of these two models (or a combination of both) would 1) be financially viable in the long run and 2) better serve the primary care and other needs of city residents including public school students living in underserved areas. Some commenters were worried that the justified desire to "put something together quickly" as opposed to establishing a "stepwise, well thought out, sustainable project" will lead to disillusionment of all concerned. They cite the experience in recent years of SBHCs that closed their doors shortly after being established due to inadequate planning.

- District-wide basic standards or guidelines governing school-based health center operations have not been established. Financial and operational arrangements for school-based or school-linked health care facilities vary widely across the nation. But states such as New York, while providing funding support of SBHCs, have set up a process for approval for each new facility that takes population need into account. The state has issued guidelines and other regulatory mechanisms for initial approval and continuing operations. Such a "floor" for staffing, equipping, and managing these facilities conditions state financial support (e.g., through a grant-based program or facilitation of Medicaid reimbursement).

- SBHCs serve low-income children many of whom are enrolled in Medicaid health plans. For a variety of reasons, a non-trivial proportion of these enrollees do not see their assigned primary care physicians (responsible for authorizing specialty services). They may find care at the school more accessible – precisely the point of setting up the health center there. But SBHCs that are not backed up by a hospital or community health center cannot provide the coverage twenty-four hours a day, seven days a week required to be a primary care provider under a Medicaid plan. Working relationships between SBHCs and health plans still need to be forged to either enter into formal contracts or to craft alternative mechanisms to reimburse centers for providing services to student Medicaid enrollees.[22]

[22] Nationwide an estimated 39% of students served by SBHCs have no other "medical home." National Association of School-based Health Centers (NASBHC): National Census of School-based health centers. School Year 2003- 2004.

- The poor oral health status of underserved children in the District was frequently raised in the course of assembling this report as an issue that requires prompt attention. SBHCs may provide dental care as part of an expanded scope of service or oral health assessments as routine care.

Facilities

- National organizations have developed facility standards for nursing suites, school-based centers, and mental health counseling offices. But no regulatory regime currently exists in the District to set and enforce minimum standards for equipping or operating these health care facilities. Currently, the space and quality of facilities vary widely from school to school. Some nursing suites lack running hot water and others have no phone, let alone Internet access. Many have no lockbox for the secure storage of student medication.[23]

- Capacity to fund the maintenance of such facilities may vary from school to school and from one year to the other. Stable funding sources have not been clearly delineated in order to meet current facility, equipment and supply stock needs in all schools.

- Proximity of nurses, SBHC practitioners and mental health clinicians located in the same school would facilitate interdisciplinary collaboration, appropriate information sharing, and continuity of care. However, nursing suites, school-based health centers and counseling rooms are not consistently co-located in the schools that provide these services.

- Nearly half of the health suites in the roughly 170 public and charter schools providing nursing services in the District are without routine online access to web-based resources such as the D.C Immunization Registry (an electronic data base

[23] See appendix 8 for data related to the state of nursing suites in public and public charter schools (including a preliminary cost estimate for bringing facilities up to standard). See also C McKibben et al. "Recommendations for constructing school nurses' offices designed to support school health services." *Journal of School Nursing.* June 2005. Appendix 9 includes the set of SBHC facility standards required by New York State. See also D Butin. "School health centers." National Clearinghouse for Educational Facilities. 2000. Available at www.edfacilities.org.

accessible through the Internet with immunization records on children and adults in the District of Columbia). In some cases, even where there is access to a computer there is no Internet connectivity. This condition hinders the nurse's ability to review up-to-date information regarding a student's immunization status and populate the registry with new immunization data. The result is often inaccurate reporting of compliance, unnecessary duplication of shots, and missed opportunities to educate parents about what immunizations are required for their children. Internet connectivity among all school-based health care facilities should greatly improve the clinician's ability to access other clinical information databases (including any future shared school health record repository critical for continuity of care) or to bill for covered services (and thus provide a revenue stream for school health services).[24]

Service level coordination and quality of care

- With the exception of the mental health program established by DMH mentioned earlier, to our knowledge there has been no formal evaluation of the quality of the services provided by school nurses, SBHCs or other school-based clinical staff. Process and outcome measures are available that reflect program performance and effect on students of the services provided. Key outcome measures that could be utilized to systematically evaluate school health services include reduction in the use of emergency rooms and improvement in school attendance.

- The level of coordination (e.g., follow up on referrals) between the school nurse and community-based specialty providers is reportedly limited. There is also need for clarity with respect to what parties (school staff, nurses, both?) are responsible for updating and securely maintaining health care records in the school.

- The degree of health information sharing among the different school-based clinicians (nurse, mental health counselor, nurse practitioner, etc.) who may be seeing the same individual student varies from school to school and is often

[24] See appendix 10 for a brief overview of school health-related information systems DOH staff conducted for this project.

minimal. Forms to collect health information are not uniform system-wide. The ability to obtain complete health information about a student (e.g., allergies, medication prescribed) from other sources of care is limited, thus compromising collaboration among practitioners and continuity of care.[25]

- There is no formal relationship between school-based practitioners and Medicaid health plans covering a large proportion of the student body to coordinate services (e.g., to identify students who may not have completed the required well-child periodicity schedule).[26] Likewise, no formal agreements are presently in place for Medicaid health plans to reimburse the SBHC for the provision of services PCPs are expected to perform for this population.

- There are currently no protocols integrating the provision of school-based health services for hard-to-reach children/youth enrolled in the Medicaid program and their assigned primary care physician (PCP). Ideally, the SBHC and the PCP would have an understanding about sharing appropriate information (e.g., assessments and recommendations), cooperate to ensure compliance with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program requirements (e.g., physical exams, immunizations), and jointly educate the family/student on the roles of SBHC and the PCP in the delivery of the student's health care.[27]

[25] The federal regulation implementing the privacy provisions of the 1996 Health Insurance Portability and Accountability Act (HIPAA) that was published by the U.S. Department of Health and Human Services in December, 2000, modified in August, 2002, and effective the following year, defines what constitutes appropriate sharing of individually identifiable health information. This rule (45 Code of Federal Regulations Parts 160 and 164) sets national standards for the privacy of individually identifiable health information and gives patients increased access to their medical records. School-based health centers administered by covered entities and, in most instances, school-based health care providers employed by an agency other than a school district and who engage in certain electronic transactions are subject to HIPAA rules.

[26] Over 50% of the children (up to age 18) in the District are enrolled in Medicaid. The Kaiser Family Foundations. www.kff.org/mfs/medicaid

[27] NYDOH. *School-based Health Center Clinical Integration Protocols.* May 2000. Included as appendix 11.

Regulation

- There is no single document or collection of documents articulating the various statutes, rules and inter-agency agreements governing the funding and provision of health care services in public and charter schools. The complex governance and multiple institutional oversight of the school system including the Board of Education, DCPS administrators, the Council as well as the participation of other entities such as DOH, CSFA, DMH, in the provision and oversight of health care services has resulted in an incomplete and at time inconsistent regulatory regime. The absence of a clearly articulated set of rules has created confusion and occasional controversy with respect to the provision of school-based services.[28] Issues on which clarity and consensus among all parties would be beneficial include:

    - Ability of SBHC practitioners to perform certain procedures (pelvic exam has been an issue in the past) and dispense medication to students otherwise unable to afford or obtain them (e.g., direct provision of antibiotics to a child diagnosed with streptococcal pharyngeal infection to treat the condition swiftly and effectively at the point of contact)

    - Ability of nurses and SBHC practitioners to dispense contraceptives and offer reproductive health counseling with pregnancy tests

    - Ability of nurses to adequately treat minor injuries occurring on school playgrounds (e.g., applying antibiotic ointment, etc.)

    - Inconsistencies between the scope of services permitted in mobile vans on school grounds and in SBHC facilities which could provide similar services

    - There is no formal system in place to ascertain the need for and the appropriate location of new SBHCs. School officials and advocates

[28] Appendix 12 contains a preliminary list, adapted from a document provided by CNMC, of the federal and local laws, regulations, policies and procedures affecting the local school health nurse program.

disagree on whether new SBHCs must obtain a certificate of need (CON) from DOH to start operations. In either case, the CON process is not tailored to ascertain the local demand for these facilities since it does not incorporate criteria to identify areas of high need. Generally accepted criteria include: high proportion of children living in poverty; of students with limited English proficiency; schools with higher percentage of students eligible for free and reduced lunch; schools that serve children/youth with significant health needs such as asthma and diabetes; schools with high percentage of Medicaid-enrolled students who have not received required well-child or other primary care services. Perhaps more importantly, there is no formal process to review provider qualifications, adequacy of funding, proposed quality assurance activities, management systems and other basic features for proposed new sites.

- As mentioned above, legislative or regulatory authority with regards to facility standards for nursing suites or SBHCs is limited. Even though the National Association of School Nurses (NASN) has issued specific guidelines, the District of Columbia has no accepted and approved standards governing the design, establishment, stocking and maintenance of health suites inclusive of supplies, equipment and dedicated space.

Program level coordination and accountability

- There has been limited program coordination in the past among DOH, DCPS, DMH, and the various community-based health care organizations under agreement or contract with these agencies. Under its Health Plus initiative in effect since SY 2000-01 DCPS has entered into a significant number (estimated at over 20) of memoranda of understanding with health care organizations to provide direct services to the general student population. The DCPS Health Plus initiative has as its overall goal "to connect students who are enrolled in Medicaid with a medical home, and to provide uninsured students access to preventive and primary

healthcare services." [29] Community-based organizations administering SBHCs, a university hospital running a pediatric mobile unit, and health plans are among the parties to these agreements under which terms each organization is able to provide free, direct health care services to students on DCPS grounds.[30] Other entities such as CNMC or DOH providing or overseeing direct services have not always been aware of these separate health care arrangements, which may nonetheless affect the primary nursing contractor operations and DOH oversight (e.g., a nutritionist and a school nurse may find themselves having to provide services simultaneously in the only health suite available).

A greater degree of transparency and consolidation of oversight are pre-requisites for increased program accountability and for creating the conditions for system-wide continuity of care, integration of mental and physical health care, and perhaps economies of scale (e.g., potentially developing a unified billing system for covered services). DCPS senior officials have met with their DOH counterparts to begin to tackle this issue during preparation of this report and have provided a copy for review of a number of MOUs signed with other agencies, health plans, and community-based organizations for the provision of health care services.

Although some gaps in coordination exist, DOH and DCPS have successfully collaborated in the coordination of health initiatives in the past. One such example has been the effort to increase adherence to national immunization standards which achieved an unprecedented level of success.[31] A forum where senior representatives from all agencies involved (e.g., DCPS, DMH, CFSA, and DOH) would regularly meet to oversee all aspects of school-based services might address any gaps or coordination issues as they arise.

[29] Please see Appendix 13 for a more detailed description of the Health Plus program prepared by DCPS.
[30] XXI Century School Fund; *School-Based Health Care and the District of Columbia Safety Net.* October 2004. (Medical homes report commissioned by DCPCA.)
[31] The most recent immunization report for the current school year indicates that over 95% of school-children have received the recommended vaccines, among the highest immunization adherence rates in the nation. DC Immunization Registry: Student immunization compliance report. January 4, 2006.

- The District of Columbia Board of Education may also issue resolutions that affect the provision of health care services. The following language from a recent Board resolution to enhance HIV/AIDS policy also illustrates the complicated governance of school health and perhaps the need for one point of accountability for all school-based services. The resolution proposed the creation of "a cabinet-level school health administrator to oversee all DCPS health-related and health-promotion activities…"[32]

Funding and third-party reimbursement

- As indicated above with respect to charter schools, current local funding through DOH appropriations is inadequate to meet the requirement that all charter schools in the District provide 20 hours of nursing services (unless coverage is extended with utilization of assistive personnel under the supervision of a registered nurse).

- Some schools entitled to 20 hours of nursing seek to obtain full-time ("supplemental") nursing coverage. An annual MOU between DCPS and DOH is the mechanism through which available funds are directed to cover a partial listing of public schools interested in this supplemental coverage. The list varies from year to year depending on individual school budgetary availability.

- Medicaid is authorized to reimburse schools as qualified providers for covered medical assistance services provided through (1) school personnel, (2) other qualified practitioners with whom the school contracts, or (3) a combination of these approaches. School-based Medicaid-covered services that qualify for federal funds include physical, occupational, and speech therapy, as well as diagnostic, preventive, and rehabilitative services. Some services are provided in conjunction with the Individuals with Disabilities Education Act (IDEA) program.[33] Others are included through a state's Medicaid plan and are available

[32] D.C. Board of Education: "Enhancing HIV/AIDS Policy for the District of Columbia Public Schools." Resolution R 06.10. September 2005. Included as Appendix 14.

[33] IDEA was first enacted in 1975. It covers children with disabilities in public schools and emphasizes special education; it also covers such related services as transportation, speech pathology and audiology, psychological services, physical and occupational therapy, and counseling. Medicaid has been authorized to cover health services provided to children under IDEA through a child's

through Medicaid's EPSDT program, which also includes screening and counseling for behavioral conditions.[34] Presumably, school nurses could bill for providing certain services under the supervision of a physician or a nurse practitioner or when standing orders for certain Medicaid-covered services are on file. Finally, in certain jurisdictions, SBHCs are considered "extension clinics" of hospitals or community health centers and can bill Medicaid as part of the operational collaboration with the sponsoring Medicaid-approved organization. However, with few exceptions, services which are potentially covered by Medicaid that nurses, mental health practitioners, and SBHC staff provide to the general student population of the District public schools are not reimbursed by that program (or other third-party payor).

- Medicaid is also authorized to reimburse schools for certain administrative costs, even if the school has not provided any medical assistance services. Examples of such allowable administrative activities include conducting outreach for Medicaid, helping applicants complete Medicaid enrollment forms, and arranging appointments with various providers of medical and screening services. Both IDEA and EPSDT have requirements to conduct activities that would inform and encourage individuals to participate in their benefits and services, and schools are considered a good location for identifying Medicaid-eligible children, including those with special needs.[35] Other jurisdictions have developed data systems that allow for the submission of Medicaid claims for covered services provided by nurses and other school-based practitioners and for administrative activities.[36] Medicaid rules are however complex and require development of infrastructure (e.g., billing, health encounter documentation, and other business systems subject to audit) not presently available in most school health facilities.

Individualized Education Plan or Individualized Family Services Plan, provided the services are covered in the state's Medicaid plan. Medicaid funds have been available for IDEA services since the enactment of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360).

[34] EPSDT is Medicaid's set of comprehensive and preventive health care services to Medicaid-eligible children under age 21. The EPSDT program provides Medicaid coverage for any medically necessary service regardless of whether the service is covered in a state's Medicaid plan.

[35] General Accountability Office (GAO). "Medicaid: Questionable Practices Boost Federal Payments for School-Based Services." Testimony, June 1999.

[36] A Sheetz et al. Developing a strategic plan for school health services in Massachusetts. *Journal of School Health*. 2002.

III. DOH Analysis

Health service program coordination and accountability for performance

Insufficient coordination of care limits the potential contribution of school nurses, SBHC and other practitioners currently acting separately to improve the health status of the school-age population. Little is known about the quality of the services provided by the entirety of programs administered by agencies such as DCPS and DOH. But experts agree that information is at the core of the primary care process and consequently nursing services, mental health services, and those provided by health center staff and other clinicians on school grounds must be coordinated.[37]

Coordination in this context may entail among other features 1) co-location of practitioners (e.g., nursing suites, SBHCs, mental health counseling office) within the same school area if feasible, 2) appropriate sharing of health records among clinicians to the extent allowed by law to facilitate continuity of care and prompt and effective referrals, and 3) consultation among interdisciplinary staff (e.g., nurse practitioner, school nurse and mental health counselor) providing services to individual students. Ideally, whatever practitioner a student happens to consult first (e.g., a mental health clinician addressing an anxiety disorder) should have the ability to access available health information and all the interdisciplinary school-based or linked services which that student might need (e.g., testing and counseling for sexually transmitted diseases).

The charge of the Council Committee on Health calls for a clear point or chain of accountability with respect to school health services. At present, no official, individual government agency, or executive body representing various agencies possesses neither the authority nor the information to govern the various program components effectively nor to set cogent system-wide policies. A unique point of accountability ***at the program level*** is needed. A robust governance structure composed of senior officials from all the relevant agencies under the operational lead of a single agency could represent such a point of accountability.

[37] J Showstack, N Lurie, et al. "Primary care: the next renaissance." *Annals of Internal Medicine.* 2003.

Such a School Health Service executive committee of senior representatives from DOH, DCPS, DMH and other involved agencies would support coordination, continuity, quality of care, and funding needs ***at the service level***. This governance structure – and the planning process that would go with it — would likely require regular (e.g., monthly) and sustained communication among senior management and joint decision making among agencies. Vertical accountability, meaning in concrete terms the ability of a parent or a concerned citizen to address an issue or simply raise a complaint related to health care services must be established. A parent should have access to clearly delineated successive levels of authority to express concerns or grievances. In the case of a complaint related to nursing services for instance, were DOH to take the lead overseeing the school health service program, these successive levels of recourse would be: a) the school nurse; b) the nurse manager; c) the contractor's designee to administer the nursing program (e.g., executive director); d) the DOH Child, Adolescent, and School Health bureau chief; e) the senior deputy director for the Maternal and Family Health Administration; f) the DOH Director.

Unified decision making among the agencies involved may result in additional benefits such as enhanced service reimbursement or other fund raising efforts. For instance, since school clinicians provide a number of Medicaid-covered services, a coordinated school health service program could in principle involve a single billing system for all school-based clinicians. Economies of scale could be achieved if all practitioners providing billable services could utilize the same system. Maximizing third-party reimbursement for services provided to the general student population would create a stable funding revenue stream available for continuing program improvement or expansion. Likewise, establishing a repository of electronic medical information accessible to the appropriate health personnel to facilitate continuity of care is more likely to occur under a unified governance structure for school health services than a fragmented system.

Educators who currently fund and independently administer some of the school health care program components may not be in the best position to appraise the quality of direct health care services. In consultation with other agencies, DOH may be more favorably situated by virtue of the training of its staff and direct linkage to

other health care funding and regulatory entities within DOH to be accountable for continuing health care quality improvement and coordination of all school services. Also with respect to expanding billing capacity to sustain services overtime, DOH may be able to readily understand and meet the complex Medicaid requirements in order to enhance reimbursement without placing an administrative burden on schools. We thus propose that DOH assume the lead responsibility for coordinating the financing and delivery and ensuring the quality of school health care services for the general student population in consultation with DCPS, DMH, CFSA, and other involved agencies.

Although the mandates and authorities of each public agency differ somewhat, these interested parties must come together at the highest levels to develop a unified agenda. Consensus from the top could contribute to the creation of a common mission, opportunities to share resources more effectively, and could also incite staff at the school level (e.g., principals, nurses) to work in synergy. We therefore also recommend that a process be established for the School Superintendent, the DOH, DMH, CFSA Directors and other concerned senior officials such as Board of Education members or their immediate designees – together with their school health experts – to jointly determine the critical policies that govern all school-based services at least during the initial phases of this plan.[38] Through this inclusive forum, perhaps co-chaired by the School Superintendent and the DOH director or their designees, unified policies could be developed with regard to:

- Responsibilities and commitments of each party
- Program models
- Mandatory and optional services
- Risk management
- Resource and expense sharing (including coordination of federal, local and philanthropic funding)
- Degree of flexibility for providers and principals to meet individual school needs

[38] Recommendations regarding governance in this section were drawn from 1) RCH Healthcare Advisors LLP: *Health Care District of Palm Beach County School Health Program: Evaluation and Business Plan Final Report*. Funded by the Quantum Foundation., April 2002; and 2) C Fisher, Pet Hunt et al. *Building a healthier future through school health programs.* 2003.

- Data management tools and evaluation process

Common decisions on these and other topics could be codified in a master memorandum of understanding among these agencies. A permanent working relationship among these agencies lasting beyond the signing of a master MOU would allow for the periodic review and update of this document.

In addition, a city-wide school health advisory committee could in principle enhance the policy making capacity of either this interagency program coordinating body and/or the lead agency for the school program. An advisory committee with representatives from community-based organizations, health care providers, associations representing health education, businesses, and other members such as parents, students and citizens from underserved areas could develop recommendations on school health programs and policies. The advisory body could communicate its recommendations to the interagency executive committee or the DOH Director's designee as the case may be. Finally, some degree of oversight authority or advisory capacity could be delegated to individual school committees including parents and community representatives, particularly in schools that have established or wish to establish SBHCs.

Evaluation of the school health nursing program

Staffing requirements. Nationally, the number and qualification of nursing staff for school nursing services varies depending upon state mandates, local school district policies, and school attitudes toward school heath services. The National Association of School Nurses (NASN) recommends that the minimum qualifications for the professional school nurse should include licensure as a registered nurse (RN) and a baccalaureate degree from an accredited college or university. In addition, NASN supports specialty certification.[39] The federal government and NASN have recommended a school nurse-to-student ratio of 1:750 for the general school

[39] National Association of School Nurses. Position Statement: The Professional School Nurse Roles and Responsibilities: Education, Certification, and Licensure. 1996

population.[40] In addition, NASN has proposed a school nurse-to-student ratio of 1:225 in "mainstreamed" special education populations, and 1:125 for severely chronically ill or developmentally disabled populations. The ratio for medically fragile populations depends on individual needs.[41]

The District of Columbia School Nurse Assignment Act of 1987 (D.C. Law 7-45) mandates that "a registered nurse shall be assigned to each District of Columbia elementary and secondary public schools a minimum of 20 hours per week." However, the law permits the use of licensed practical nurses (LPN) to supplement the registered nurse work force in meeting the required 20 hours per week. Licensed practical nurses are not included in the current skill mix under the school health nursing program. Our preliminary review for this plan of the statutory provision suggests that no legislative change would be required to implement alternative nursing staffing models that would expand services utilizing assistive personnel such as LPNs and provide adequate coverage in all schools.

LPNs are qualified to perform a variety of functions under supervision that are currently performed by RNs. These include

- Student reassessments to determine health needs and the provision of nursing care planned by the RN (including g-tube feedings, tracheotomy care, urinary catheterizations, etc.)
- Student health record documentation
- Medication administration
- Health screenings

Among the 170 schools currently covered by the nursing program, 63.5% (108/170) receive 20 to 24 hours of registered nurse coverage per week while 36.5% (62/170) of the schools receive 40 hours of coverage each week. The average nurse-to-student ratio (number of students enrolled / number of FTE nurses) is roughly 700:1. This ratio meets the recommendation from NASN and the federal publication

[40] U.S. Department of Health and Human Services, (2000). Healthy people 2010. Available at http://www.health.gov/healthypeople/document/html/volume1/07ed.htm#_Toc490550856
[41] Harrigan, J. (2002). Overview of school health services. Castle Rock, CO and Scarborough, ME: National Association of School Nurses

Healthy People 2010. Although it may suggest adequacy of the current nursing work force overall, the ratio does not reflect key factors to consider in achieving appropriate nursing staffing for each school in the District according to need.

For instance, some schools with a full time nurse may have low student enrollment and no significant medically fragile student caseload whereas other schools with more than 1000 students with unresolved health concerns (e.g., adolescents with no source of primary care) may also have one full-time nurse providing coverage. Finally, the student-to-nurse ratio would be much higher than the one mentioned above if the student population of the over 30 public charter schools that do not have nursing coverage at present were included in the calculation.

In sum, current staffing practices under the nursing program are not conducive to placing nurses according to student enrollment and medical need. We recommend a thorough revision of staffing models and practices over the ensuing months to reach the goal of full-time coverage for the whole student population of public and public charter schools.[42]

Quality Assurance and improvement. School nursing as a specialty, lacks the research to support the effectiveness of its practice. Quality indicators to evaluate practice are also inconsistent used. Although school nurses still tend to be evaluated by the tasks they complete and their frequency, interest on the part of payors and hiring organizations is starting to shift from a focus on process to one on student outcomes, that is, the actual results of the health care interventions nurses conduct. Attempts in the school nursing field to identify and adopt outcomes by which the effectiveness of intervention is measured are still in their infancy though.[43]

Thus, rather than focus on still poorly developed outcome measures, we propose first to concentrate on improving essential structural and procedural aspects of a quality nursing program that are pre-requisites for establishing a student outcome measurement and evaluation system. These structural and process components

[42] Appendix 6a includes alternative staffing patterns proposed by CNMC as a starting point for this task
[43] J Selekman and P Guilday. "Identification of desired outcomes for school nursing practice." *Journal of School Nursing.* December 2003. Appendix 6b includes desired outcomes and potential quality indicators identified by this study.

include, for example, a) expanding the capacity to provide school health nursing services to all students in District public schools, b) ensuring that providers are well trained and qualified; c) generating the capacity to reliably collect valid data throughout the nursing program to drive the outcome indicator development process. We propose to follow the advice of quality improvement experts who make the following observation in this respect:

"In the health care industry, dysfunctional systems have cost organizations of all sizes vital resources, production capacity, staff satisfaction, and patient safety. Recognizing the urgent need for transformation, many health care leaders implement full-scale improvement initiatives — yet later find the implementations gone awry, their systems unchanged and over budget. To achieve sustainable results, organizations must utilize a process improvement methodology that incorporates simple, teachable concepts, applicable tools, and a plan for culture shift."[44]

Nonetheless, as the fundamentals mentioned above are put in place we will set structure and process performance standards. We plan to subsequently explore implementation of a quality improvement mechanism in consultation with health care providers, the nursing program contractor, and experts in health care quality. At a minimum, systematically evaluating the quality and effectiveness of particular school-based services will entail a) reliable data collection, b) formulating interventions to improve practices and associated outcomes, and c) observing the results of implemented changes and d) learning from its consequences.

Independent program evaluation. The nursing service program administered by CNMC has not undergone a comprehensive evaluation since its inception in 2001. Like the District, other jurisdictions have also faced challenges to the sustainability of school nursing programs (e.g., demands for additional funding due to new schools coming on line, potential shortages of registered nurses). In some cases, the community has involved a foundation to sponsor a cooperative study on behalf of the local educational and health authorities overseeing the school program.[45]

For instance, in Palm Beach County, such an independent evaluation included consideration of "quality, efficiency, scope of services, outcomes and potential new

[44] Institute for Healthcare Quality Improvement (IHI). Website accessed on January 21, 2006. http://www.ihi.org/IHI/Programs/ConferencesAndTraining/ImprovementEssentials.htm
[45] See RCH Healthcare Advisors LLP: *Health Care District of Palm Beach County School Health Program: Evaluation and Business Plan Final Report*. Funded by the Quantum Foundation., April 2002. Available as Appendix 15.

sources of revenue." The study team observed school nurses in operation, conducted interviews with nurses, school district officials and principals, health administrators and other stakeholders, reviewed programmatic data as well as practices in other communities. The study team included social science researchers, nurse experts, financial analysts, and attorneys.

In section IV below we suggest measures to address some of the questions raised about the District school nursing program. Among these, we believe that an independent "top-to-bottom" review of current nursing program operations and resources is warranted to better match the skills of caregivers with student needs, improve staff satisfaction, and effectiveness in service delivery. This evaluation should also look at the interface and linkages between SBHCs and school nurses including questions such as whether SBHC staff could perform nursing program duties (thus easing registered nurse staffing requirements in the schools where health centers are established). Importantly, the evaluation should fully explore sustainable financial models and, in particular, Medicaid reimbursement rules since nursing services provided to the general school population in the District are potentially covered by Medicaid but are not currently billed.[46]

We also intend to continue to work collaboratively through regular monthly meetings with CNMC, DCPS, DMH and any other interested agencies on 1) the continuous improvement of the school nursing program under the current contractual agreements, and 2) the development of a thorough scope of work for the new nursing service contract to improve services, facilitate contractor program management, and departmental oversight.

School-based and school-linked health centers

Coordination with the school nurse. At present there is no formal coordination between CNMC nursing staff and established school-based centers. Such coordination could increase efficiencies (as well as the likelihood that private funding be forthcoming to support development of the school health service infrastructure).

[46] Appendix 16 contains a brief review of issues associated with third party reimbursement for school nursing services produced by NASN.

However, in at least on instance the informal relationship established between a CNMC nurse (RN) and a school-based nurse practitioner (NP) has allowed the RN to concentrate on the health education and health promotion aspects of her mandate with individual kids and their families while the NP serves as the direct health provider assessing, treating, and ensuring follow up and/or referrals. Preliminary data suggest that this arrangement has increased children's time in the classroom and parents' work attendance (which may translate into higher income for many immigrant workers who are paid on a daily basis). In addition, the NP can also focus on health education targeted to teachers and on integrating health education into the general school curriculum.[47]

SBHC funding. Financial models to sustain SBHC programs vary widely across the country. Funding comes from grants to federally qualified health centers (FQHCs), state appropriations, state allocation of federal maternal and family health block grant funds, local foundation and community groups, students and families served, and reimbursement from public and private health insurance. These monies are thus directed towards the health centers per se (e.g., grants) or are tied to individuals served by them. Medicaid fee-for-service payments and billing to Medicaid health plans have accounted for a small proportion of revenues for SBHCs nationwide, with the possible exception of New York State where a robust Medicaid reimbursement system is in place.[48]

Although advocates tend to consider securing a solid Medicaid funding stream the best opportunity to take these programs to scale, barriers must be overcome in many states and localities to recovering Medicaid reimbursement. For instance, SBHCs are not universally recognized by state Medicaid agencies as a provider type. Opportunities to forge working relationships to address issues of common interest between Medicaid health plans and SBHCs have been limited in the past (e.g., coordinate care with PCPs, authorize specialty referrals, or establish reimbursement mechanisms).

[47] Maria Gomez. Personal communication. January 2006. Mary's center is currently performing an independent evaluation of its direct services and educational curriculum at Brightwood elementary school. January 2006.
[48] Julia Lear. School-based health centers: Policy and practice. Slide presentation, National Council of State Legislatures website. Accessed on December 1, 2005.

However, good-faith efforts to coordinate funding and service delivery between health plans and centers (or alternatively, to establish SBHCs as extensions of community-based providers already certified by plans as primary care providers) could be beneficial for both plans and providers. Potential benefits are

- Improved access to health and mental health services in schools is likely to reduce inpatient and emergency room use for Medicaid enrollees (easy access and effective management could have the most impact with regard to reducing preventable ER visits or hospital admissions for enrollees with chronic illnesses such as asthma, diabetes or depression)

- Improved ability to meet federal and local quality performance standards that have proven challenging for MCOs to achieve (e.g., immunizations, well child exams).

States with policies designed to enhance Medicaid as a source of funding for SBHCs vary in their approach. Public health insurance practices may range from a) mandating health plans to establish provider contracts with the centers, to b) carving out funds from capitated payments to health plans commensurate with the volume of services provided by SBHCs, to c) requiring plans to develop other reimbursement mechanisms in collaboration with SBHCs.[49] Of note is that states that facilitate Medicaid reimbursement for SBHCs also typically set facility, staffing and quality standards for them that are consistent with health care industry practices.

School health center models. Consensus has not been reached yet among otherwise collaborating community-based groups on whether the widely supported expansion of primary care and specialty services for the general student population should be centered on school-linked, school-based health centers or a combination of models. As a starting point towards reaching agreement, we propose that the District

[49] John Schlitt. School-based health care: Trends in financing. Slide presentation, National Council of State Legislatures website. Accessed on December 1, 2005..

seriously consider the school-based model utilized by New York State.[50] Below are some of the reasons that would justify building on that state's experience:

- New York State has the most extensive SBHC program in the country with roughly190 approved, operating facilities (of which 2/3 are in New York City, an urban environment with socioeconomic and chronic health conditions comparable to the District)
- The program has been in operation for over two decades and has proven robust and sustainable
- Approval of new school health centers is needs-based and thus minimizes duplication of services with other publicly funded entities
- The standards require that SBHCs guarantee health care access for the school population 24/7.
- The model appears to be compatible with the concurrent operation of both SBHCs and SLHCs in the city, and is likely to be consistent with the DC Medical Homes initiative (e.g., it is need-based; providers authorized to operate the school centers as "medical homes" are community health centers and hospitals)
- Includes Medicaid reimbursement as a stable programmatic funding source in a context with high Medicaid managed care penetration. The reimbursement arrangement does not appear to require the development of a state plan amendment since SBHCs bill through their sponsoring institutions which already are Medicaid providers
- Well-developed tools to support application process, budgeting, quality improvement and other monitoring activities have been made publicly available.[51] Other jurisdictions have already profitably adopted consent

[50] Appendix 17 contains a) principles and goals of New York State's School-based Health Center program and b) guidelines specifying state requirements with respect to: access to services, parental consent, scope of services (core and expanded), staffing, relationships (student's family, community, sponsoring institution, etc.), organization, fiscal operations, data management, facility, and quality improvement for these health centers. We understand that other states (e.g., Colorado, Michigan, Louisiana) have systems worth exploring as well.

[51] We have obtained from our colleagues in New York an application packet that contains, in addition to the principles and guidelines mentioned above, definitions, staffing table templates, Medicaid billing information, statement of assurances, work plan, SBHC site-specific information form, memorandum of understanding (MOU), budget forms and instructions, performance effectiveness review documents and other tools. New York Department of Health, School Health Program: *Application to Establish a School-based Health Center in New York State.* July 2005.

procedures, core service, school-health center staffing guidelines or other standards that have been in place in that state for years.

We believe that the various documents that the NY DOH School Program staff has made available to us embody useful experience and lessons learned over years of operation and could serve as the basis for a fruitful discussion among stakeholders in the District even if the model or models eventually implemented in our city (e.g., school-linked, school-based, or both) differ from the one selected in that state.

Any model selected should probably provide access to a medical home 24/7 (e.g., for parents to consult or for children to be evaluated on the many days when schools are closed). Ultimately, once the public has had an opportunity to discuss the available alternatives, we propose that DOH set standards, be responsible for regulatory oversight, and for SBHC program evaluation.

IV. Proposed strategies and timeline for implementation

In order to attain the main mission of a coordinated school health service – to improve the health status and ability to learn of school-age children – we sought to develop practical recommendations consistent with the following general goals:

- Clarify and improve the lines of accountability for school health programs
- Clarify the roles and responsibilities of the city agencies involved
- Make the school health system more open and transparent to the public to enhance public participation and input
- Improve access to and quality of primary care for the general student population in public schools
- Provide case management of medically fragile students including those with chronic illnesses
- Define roles and set agreed-upon standards for nursing, DMH mental health, and SBHC staff
- Improve coordination of services among these practitioners and with the larger health care system

- Identify clinically sound and financially sustainable school-based and/or school linked operational models that are integrated into the city's primary care landscape
- Improve working conditions and set standards for all school-based health care facilities (i.e., nursing suites, SBHCs, mental health offices)
- Measure and assess program performance as a basis for quality improvement over time (e.g., student health outcomes, school attendance)

The documents provided by NY State on SBHCs (Appendix 17) and by CNMC on an expanded nursing program (Appendix 7) contain additional goals that school health centers and nursing programs should plausibly meet in the District of Columbia. In addition, these documents include useful descriptions of standards pertaining to scope of service provided, staffing, facility and other requirements. We propose that these goals and standards be open for public comment for 90 days from the date of the hearing on January 30, 2006 and that DOH in consultation with other agencies incorporate such comments. DOH would then issue final guidelines on these two key school health service programs no later than 30 days after the closing of the public comment period. A copy of this report with its appendices will be available for public review at 825 North Capitol Street, NE; Washington DC 20002, suite 3112 (third floor).

The steps proposed in this section span the first year of the plan. During that time we would implement decisions agreed-upon by all stakeholders, devote ourselves to finding consensus on issues outstanding, and to further refining the plan and specifying implementation timelines as those decisions are reached.

Although many of the strategies we discuss are commonsensical, experts warn about the surprising complexity of school settings and the political and implementation challenges reform proposals face. Those we consulted over the last few weeks noted that other jurisdictions that have successfully reformed their school health care programs have often engaged outside expert assistance to develop a robust plan with sensible timelines for implementation. The experience of other cities like Denver, Baton Rouge, Chicago, Boston, and counties such as Palm Beach and

Broward (FL) indicates that completing this planning process alone including outside expert support has taken approximately one year. [52] The variety of levels of knowledge, mandates and interests represented among stakeholders requires meaningful participation and time to reach the consensus needed for program funding, governance, standards and their implementation.

Below we describe strategies along the one-year timeline. Some could be implemented immediately (within a month of plan submission). These are measures that do not require legislation or substantial additional resources but are rather operational improvements that all parties involved have found appropriate and desirable and whose prompt implementation they support. (A summary table that classifies all tasks by time period and category – governance, facility infrastructure, service coordination, funding— can be found at the beginning of this document).

Tasks already implemented at plan submission

- Appraised existing school-based health services and solicited comments from DCPS, DMH, CBOs, providers and other interested parties on the draft status report and proposed strategies
- Solicited input from DCPS and others, obtained documentation from other jurisdictions to develop the scope of work for a new contractual agreement to administer the school health nursing program
- Selected and proposed facility standards for health suites
- Selected and proposed facility standards for SBHCs
- Obtained an assessment of the condition of health suites based on accepted standards
- Explored (with DCPS and CNMC) mechanisms to integrate school nurses into Student Support Services Team (SST), a recently established multidisciplinary team in each school to assess individual student needs
- Obtained proposal for alternative staffing model for school nurse program
- Selected and proposed service, staffing and other standards for SBHC (NYS) and nursing services (CNMC)

[52] Julia Lear: personal communication. October 2005.

- Developed cost estimates for: a) providing full time nursing service coverage for all schools (including staffing model with LPNs); b) bringing health suites into compliance with accepted standards; c) providing services at SBHCs

By first month after plan submission (February 28, 2006)

- Review all existing MOUs and contracts related to the provision of school-based health care services to complete an inventory of all health care provided on school grounds by all providers. This task is a pre-requisite for appropriate consolidation and future coordination of school-based health care.
- Develop in consultation with DCPS and other agency partners the scope of work for the RFP on the school nursing program in preparation for the new contracting cycle. At a minimum, the RFP would stipulate that a program evaluation be included among the provision of the new contract
- Adopt standards for health suite accommodations based on the recommendations of the National Association of School Nurses
- In consultation with HRLA, explore feasibility and authority to inspect and certify compliance with standards for health suites and other school-based facilities
- Establish a DOH-led multidisciplinary project team comprised of DOH information technology (IT) and program staff; school health nurse contractors; DCPS IT, facilities, and program staff; DMH IT and program staff; charter school representatives; and appropriate OCTO staff. Tasks assigned to this team would include: a) conduct an up-to-date facilities assessment to cable and equip school health suites; b) develop a health information needs assessment defining the requirements of the nurses and others involved in school health. (There should be significant consultation and involvement of school nurses in the development and introduction of the new system to facilitate acceptance and adoption by this group and to develop a useful and user-friendly product); c) adopt approach on how to upgrade the school health facilities in each school; d) develop plan to integrate and link the appropriate information systems with each school-based health facility; e) prepare a budget and timetable for implementation for the facilities improvement and development of the information system.
- Ensure that nurses and SBHC staff participate in the student Support Services Team (SST) at each school

- Ensure that school nurses and SBHC staff participate in the Multi- Disciplinary Team (MDT) responsible for developing an individualized education plan (IEP) at each school.
- Establish a policy that a) a copy of any individual health plan (IHP) available at the school is securely maintained in the health suite; b) all medically fragile children have an IHP on file in the health suite. Develop a method to communicate information to the primary care provider (medical home) outside of the school and to facilitate necessary referrals
- Explore and seek to establish temporary reimbursement arrangements between the Medicaid health plans and currently operating SBHCs to reimburse health centers for documented well-child and other covered visits for hard-to-reach Medicaid-eligible students. Such an mechanism could potentially involve the following steps: 1) health plans, in collaboration with DOH and SBHCs, identify schools with a large proportion of Medicaid-enrolled children that are out of compliance with EPSDT requirements (e.g., utilizing the immunization registry and Medicaid MCO databases); 2) SBHCs obtain parental consent for the provision of well child care; 3) health plans and SBHCs arrange for the provision of these services at SBHCs including transportation as needed; 4) SBHCs document the visits and submit a bill for the services provided to the MCOs.
- Develop a financial statement that describes funding allocated by each of the various DC government agencies to school-based clinical services. It would be useful to separate the services by those directed to the general population and to students enrolled in special education and those with individual health plans.

By the third month (April 30, 2006)

- Time constraints and staff limitations during the preparation of this proposal precluded us from consulting with parents, students, principals and many others potentially concerned about school health services. Accordingly, DOH will convene a "town hall meeting" or "listening session" to provide an opportunity for parents, students and citizens generally to convey their views on the school health plan. DOH is interested in holding these meetings at regular intervals throughout the implementation of this proposal.

- Develop a master memorandum of understanding among DCPS, DOH, DMH and any other relevant agency to clarify and articulate responsibilities of each agency. Such a document would clearly delineate the role of each agency in contributing to an effective and coordinated school health service program, and the commitment to maintain a working governing structure. The recent MOU between DCPS and the Metropolitan Police Department (MPD) for the provision of security services could serve as a template for this sort of agreement.
- Convene a discussion among all key stakeholders on viable financial and operational models of school-based and/or school-linked health centers for the District. The District of Columbia Primary Care Association (DCPCA) has recently convened an Adolescent Health Advisory Group of city experts and advocates as part of its effort to certify clinical, financial, and governance-related health center performance under its Medical Homes DC project. DCPCA has proposed that this advisory group, which includes other stakeholders concerned about school health, be the venue for discussion of one or more sustainable models that the city government could support. Members of the DC Assembly for School Health have also expressed a willingness to participate in this consensus-seeking discussion. Alternatively, DOH could convene a town-hall meeting or otherwise develop an inclusive and participatory process with all concerned stakeholders to discuss this fundamental component of the architecture for a coordinated school health program. DOH would then be responsible for issuing standards for existing health centers, and those to be established in the future, overseeing compliance with those criteria, and evaluating health center performance.
- Establish a School Health Service executive committee of senior representatives from DOH, DCPS, DMH and other involved agencies
- Adopt a student bill of rights
- DCPS convenes panel to review content of HIV/STD/teen pregnancy prevention curriculum supplement to be used in school year (SY) 2006-07 and integrated into the health education curriculum (scheduled for adoption in SY 2007-08). A Content Review Panel approves supplemental materials used to enhance instruction. "Supplemental" materials are media resources (texts, brochures, etc.)

that address specific content areas. These are selected based on adherence to national standards and CDC guidelines

- Develop with DCPS an improvement plan for all health service facilities. Standards should address space and facility requirements (including co-location of practitioners) as well as equipment, supplies and hygienic maintenance. An interagency agreement could clarify the parties responsible for funding as well as enforcing these requirements.
- Develop a uniform IHP form or template for use in all schools
- Explore adoption of the standard medical record form for EPSDT evaluations
- Review status of school-based oral services and explore possibilities for expansion
- Adopt policy statement defining the "medically fragile student" in the school population
- Develop and distribute a system-wide brochure that provides an introduction to the school health nursing program and includes information about what nurses do, when it is appropriate to go to the health suite, how emergencies are handled, and other relevant information about the program.
- Conduct a thorough revision with CNMC of nursing staffing models and practices; ensure that current legislation allows for expansion of nursing coverage utilizing LPNs and other assistive personnel
- Define sources of funding and seek resources to bring school nursing suites, counseling offices, and SBHCs up to standards.
- Explore the possibility of establishing contracts for the provision of Medicaid-covered services by SBHCs to health plan enrollees on a regular basis and/or for the coordination of services between SBHCs and primary care physicians under contract with Medicaid MCOs. Formalizing the relationship between health plans and SBHCs to facilitate services to hard-to-reach enrollees has the potential of reducing ER visits and preventable hospital admissions, and increase compliance with EPSDT requirements.
- Contingent upon the model chosen for school-based or school-linked services, develop a feasibility study and potential design of a unified billing system in collaboration with the Medical Assistance Administration (MAA), the Office of the Chief Technology Officer (OCTO), community-based providers, Medicaid

managed care organizations, school-based staff, CNMC, system vendors, and any other appropriate party.

- Secure funding (e.g., a foundation grant) to enter into a contract with an entity with the capacity to independently evaluate the school nursing program. The expert contractor team could also assist with the design of a fully comprehensive plan (including other components not yet incorporated in the core plan such as a nutrition services or services for disabled children).
- Develop funding mechanisms to provide the number of hours stipulated by law to all public and charter schools in the District.
- In consultation with DCPS, develop a process to fund "supplemental" nursing coverage in selected schools that is predictable, timely and fair to all interested schools.
- Seek funding to provide full time nursing coverage through alternative staffing models (e.g. use of LPNs to supplement RN coverage)

By the sixth month (July 31, 2006)

- Complete and sign master MOU between DCPS, DOH and other involved agencies
- DCPS and partner agencies will develop a district level wellness policy that addresses physical activity and nutrition for implementation in SY 2006-07
- Charter and establish a school health service advisory committee. Members would be expert representatives as well as parents, students, child advocates and other concerned citizens. This body would assist the multi-agency executive committee and/or the designated official responsible for the school health service program in identifying programmatic needs and recommending steps to address them. The committee would be staffed by DOH and DCPS personnel. Advisory committee meetings would be open to the public and could offer an opportunity for expert and lay person testimony to increase the transparency and accountability of the school health service governing structure.

  Of note is that this body could also provide advice on selecting sites for new SBHC capacity development based on need assessment studies. Committee approval of a new site could resolve the issue of whether a certificate of need is

legally required for new construction or not, an issue which has created confusion among SBHC advocates and other stakeholders.

- Draft policy statement specifying approval process for establishing SBHCs and/or SLHCs based on geographic need and sets standards/guidelines for health center operations
- Issue standards/guidelines regarding scope of service, facility and other requirements for the nursing program
- Let contract with expert outside entity to evaluate nursing program and recommend further steps
- In the context of the school health IT project team, DOH will collaborate with DCPS, CNMC and others to provide computer equipment, and connect school nursing suites that have "live" phone and "live" data wiring to a DOH computer system. A survey of current wiring and jacks in all health suites will be needed to fully estimate the cost and time required to provide connectivity in all schools. DCPS and DOH IT staff has estimated that voice and data connections could be "live" in the desired locations within six months once the survey is executed. Completion of this task, although technically feasible within the timeframe proposed, is contingent upon availability of funds and the timely approval of contractual agreements for implementation.
- The IT project team will complete a feasibility study on implementation of shared electronic health record system for the schools. Internet connectivity is a pre-requisite for achieving online health record sharing among authorized practitioners to avoid costly service duplication and enhance continuity of care, as well as for moving directly to paperless billing for services. Online access to program eligibility data could also permit practitioners to more or less readily function as eligibility brokers at the point of service.
- Establish minimal standards of care for all school-based health services (nursing, mental health, SBHC). Working in collaboration with the relevant agencies as well as community-based groups and utilizing practices proposed by professional organizations, establish a set of standards of care for the school nursing, mental health, and school-based health centers. The standards could be articulated in a school health policy manual and would include prevention, diagnosis, treatment, and referral responsibilities of the school nurse and other health care providers.

- Also ensure the adoption of protocols or guidelines for those instances where a student enrolled in a SBHC has an outside primary care provider to develop appropriate linkages and coordinate the delivery of care. As a starting point we propose to ground this discussion among Medicaid managed care plans, community-based health care providers, and city agencies on already available guidelines developed in other jurisdictions with high penetration of Medicaid health plans among the school student population. [53]
- Complete study of financial models supporting SBHCs or SLHCs in other jurisdictions
- Develop FY 2008 budget request that includes school health service funding for 2nd year of plan implementation

By the 9th month

- Draft policy statement specifying approval process for establishing SBHCs or SLHCs based on geographic need
- DCPS convenes standards roundtable to develop health education curriculum. The DCPS Office of Academic Services will incorporate health education standards as part of the Superintendent's mandate for education reform. State standards are scheduled for formal adoption for SY 2007- 08
- Develop a secure, HIPAA-compliant system of collecting, maintaining, sharing and reporting student health data. Promote adoption of the already developed single medical record form (SMRF) for EPSDT services in all public schools.
- Adopt structure, process and outcome measures, as well as continuous quality improvement procedures for all school health services. In addition to exploring the quality improvement tools utilized in other jurisdictions, we will assess relevant tools such as, for example, the one developed for SBHCs by the Center for Health and Health Care in Schools, which focuses on seven clinically based "sentinel conditions" by age group. These are conditions "that stand out because they represent typical health risks for that age and because they may serve as a measure of good health care delivered."[54]

[53] See appendix 11. NYDOH. *School-based Health Center Clinical Integration Protocols.* May 2000.
[54] The Center for Health and Health Care in Schools: *Method of Evaluation of Clinical Services in School-Based Health Centers.* CQI Version 1 September 1, 2001.www.healthinschools.org/cqitool.pdf. This tools could probably be adapted for nursing services.

By the 12th month

- Complete evaluation of school nurse services and determine next implementation steps towards comprehensive school health program
- Propose legislation for any regulatory change required to further the reform of school nursing, mental health and SBHC services
- The multidisciplinary school health IT project team completes development and implementation of new IT software and training of nurses and other appropriate staff in schools with Internet connectivity. For instance, contingent upon the progress the District of Columbia Partnership to Improve Children's Healthcare Quality (DC PICHQ) achieves in establishing a secure electronic shared record registry for EPSDT data for all children enrolled in Medicaid, the IT project team would oversee implementation of this shared health record registry in schools with available Internet connectivity.
- Finalize billing and reimbursement arrangements between Medicaid health plans and current SBHCs.

Over the course of the first year of plan implementation we will continue to gather, analyze and summarize data and information to further appraise the existing components of school-based health services. We will monitor the performance of the school program in consultation with the city Administration and the Council.

In conclusion, this plan will not succeed by anticipating all contingencies over the next year or two. In fact, stakeholders have commented that the proposed timeline is overly rigorous and perhaps unrealistic given the number and variety of tasks proposed and the multitude of parties with an interest in the process on which successful implementation depends. As we proceed with implementation, the ability to have properly competed contracts approved by the procurement authorities, to secure funding from private sources, or if necessary to pass legislation and issue regulations – to name just a few challenges – will not be dependent on the efforts of DOH alone.

Clearly, the map is not the territory. But we trust that all parties interested in school health (and citizens in general) will utilize this document to guide an ongoing conversation on this important issue to make sure that a coordinated school service is implemented in the District in a timely manner. Accordingly, and in addition to taking into account the public testimony provided at the upcoming hearing on January 30th 2006, we intend to seek opportunities to obtain public comments and refine aspects of this proposal – including but not limited to the reasonableness of its timeline. Ultimately, the plan will be fruitful if it leads to implementing a unified policy making process for school health services with the capacity to set standards, oversee, and evaluate school health program outcomes and, critically, use public input to self-correct over time.

V. DOH Response to Council Committee Questions

The Committee on Health and the Committee on Education, Libraries and Recreation held joint oversight hearings in the Fall of 2005 on school health. During the last of these hearing on October 26, 2005, the joint Committees requested that DOH provide a plan proposing the architecture of an effective school-based health system and posed a number of questions to be addressed in constructing the plan. This section addresses the specific questions posed then by the Committees.

1. The mission statement included in the [October 26, 2006] draft report was subject to further refinement. What is your timeline for completion of this task?

We propose the following mission for the school health programs involving nursing, mental health, school-based and school-linked health center services. The statement reflects the current mission of the Department of Health while centering on the school population.

"To protect the safety, promote health-enhancing habits, prevent illness, and provide equal access to quality healthcare for all District of Columbia public and public charter school students in order to improve their health status and educational attainment."

2. Guiding principles and goals that should direct school-based health programs are identified in your [October 26, 2006] report. What guiding principles and goals will direct the school-based health program proposed for the District?

In section V we identified a set of general goals that inform the plan presented to the Council

- Clarify and improve the lines of accountability for school health programs
- Clarify the roles and responsibilities of the city agencies involved
- Make the school health system more open and transparent to the public in order to enhance public participation and input
- Improve access to and quality of primary care for the general student population
- Provide case management of medically fragile students
- Set guidelines for nursing, DMH mental health, and SBHC staff
- Improve service coordination among practitioners within and outside the schools
- Identify a clinically sound and financially sustainable school health center model
- Improve physical condition and set standards for all school-based health care facilities
- Measure and assess program performance as a basis for continuing quality improvement (e.g., student health outcomes, school attendance).

We suggest that these goals as well as the standards pertaining to scope of service, staffing, facility and other requirements proposed in this plan be open for public comment for 90 days from the date of the hearing on January 30, 2006. DOH in consultation with other agencies would incorporate these comments and issue within 30 days after the comment period ends final guidelines for school health centers and nursing programs that would also include a comprehensive statement of goals and principles for these programs.

3. What is your timeline for development of systems and policies to actualize these principles and achieve the identified goals?

The timeline for development of systems and policies to actualize these principles are addressed in section V and also summarized in the timeline following the introduction to this proposed plan.

4. How many schools will offer the identified services?

All public and public charter schools should receive a minimum of 20 hours of school ***nursing services*** as stipulated by D.C. law. In consultation with CNMC and in the course of the evaluation proposed in this plan for the current nursing program, we will explore alternative staffing patterns to obtain full-time coverage in as many schools as possible, starting with those with a disproportional population of medically fragile children.

With respect to ***SBHCs***, according to the standards proposed in this plan, a multi-disciplinary team consisting of a mid-level practitioner, a mental health counselor, and a medical assistant will provide in consultation with a physician the

services summarized below to all children who have a signed parental consent form in schools with a SBHC.

- Comprehensive physical health and mental health assessments
- Diagnosis and treatment of acute illnesses
- Screenings (e.g., vision, hearing, dental, nutrition, TB)
- Routine management of chronic diseases
- Health education
- Mental health counseling and referral
- Immunizations
- Referral and follow up

The decision to establish a SBHC will be based on assessment of needs and resources. In principle, schools with students who present with the highest medical and psychosocial need will be priority candidates for the establishment of SBHCs (or SLHCs as the case may be).

5. Will these services be offered in all school-based health settings?

Please see response to question 4.

6. Please identify what services will be available through the school nurses program?

Appendix 7 contains the scope of services CNMC plans to offer under the nursing program the hospital is currently developing. As mentioned above, we propose to have a public discussion over the next couple of months to refine the scope of school nursing services based on this preliminary document and to set DOH guidelines accordingly after the public comment period ends.

7. Will services offered through the school nurse program vary according to school type (elementary, middle, senior high)?

As indicated in Appendix 7 all school levels will receive the same services with the following exceptions for services provided only in the grade levels indicated:

<u>Elementary and Middle Schools</u>

- Health appraisal review including measurements of height, weight, and blood pressure on 2nd, 4th and 6th grade students, special education students and all A-3's (transfers and new students).
- Sexual Assault Prevention program in all elementary schools in collaboration with DCPS staff, D.C. Metropolitan Police Department, and DOH.
- Prevention of smoking in coordination with local chapter of American Academy of Pediatrics, CNMC pediatric residents, and other health care providers and/or community-based organizations.
- Vision screening - on Pre-K, K,1st, 2nd and 6th graders, and un-graded students in all schools
- Muscle balance screening for kindergarten students
- Color blindness screening for all 1st grade students

- Scoliosis screening – grade 6th with education awareness component for all students
- Hearing screenings on Pre-K, 1st, 2nd, 4th, 6th and un-graded students

Junior High and High Schools

- Vision screening – grades 8, 10 and un-graded class
- Scoliosis screening – grade 8 with education awareness component for all students
- Implement the AIDS Prevention program including condom-availability per established protocol.
- Collaboration with Addiction Prevention and Recovery Administration (APRA) staff to implement substance abuse prevention education within the schools.

8. Have you determined a uniform scope of core services to be offered by school nurses in elementary, middle and senior high schools?

We have proposed a uniform core of nursing services moving forward. Please refer to answers to questions 6 and 7.

9. Have you determined a uniform scope of core services to be offered by school-based health centers?

We have selected and propose to adopt (with any changes required by local rules and circumstances) the set of core services the New York State DOH requires for operating SBHCs. SBHCs must provide a core of services including primary and preventive health care, diagnosis and treatment of medical conditions, and management of chronic conditions. SBHCs in that state must also address mental health problems either by referral or on-site services and provide oral health assessments as part of the routine care. Please see Appendix 17 for a more detailed description of these core services

10. What is your timeline for making these determinations?

As indicated above, we expect to issue guidelines on scope of service for nursing and SBHC programs by April 30th 2006. (Please see summary timeline and section IV).

11. Your [October 26, 2005] draft report indicates that the following providers "will be included in school-based service delivery

• Physicians and nurse practitioners
• Nursing personnel
• Oral health providers
• Social service personnel
• Physical and health educators
• Psychologists
• Licensed counselors
• Social workers"

a) Have you determined your core health staff requirements for school-based health centers? b) What is your timeline for developing core health staff requirements for school-based-health centers?

a) Based on the NY State guidelines (Appendix 17), the following are the proposed requirements for SBHC core health staff:

- Nurse practitioner
- Collaborating/supervising physician
- Mental health counselor (MSW or LSW)
- Registered nurse
- Health technician
- Clerk

b) We will finalize guidelines for SBHC staffing and related requirements by April 30th 2006. (Please, see response to question 10).

12. Levels of service are clearly defined in the [October 26, 2006] draft report. What minimum levels of service will be provided in school-based health centers?

Please see response to question 4.

13. What minimum levels of service will be provided through the school nurse program?

In consultation with DCPS, CNMC and other parties (charter schools in particular), and under existing rules and resource limitations, DOH will continue to seek to extend the minimum level of services provided by CNMC to all public and public charter school students. The basic level of required service under current contractual arrangements involves a) 20 hour weekly access to a registered nurse; b) "review of immunization status, basic health screenings, and education and prevention programs for smoking, nutrition, pregnancy, HIV/AIDS, substance abuse and mental illness (…) School health nurses are also responsible for implementing effective referrals into the larger health care system when a health need is identified."

At the same time, we propose in this plan to continue to explore with CNMC alternative staffing patterns for the nursing program. We also propose to commission a formal evaluation of the nursing program that would include a study of various staffing models. As indicated elsewhere in this document, we have reason to believe that alternative staffing models, which include LPNs and other assistive personnel, are probably permissible under current law. Alternative models may improve the efficiency of the nursing program and bring us closer to attaining the goal of full-time nursing coverage for all public and public charter schools. Likewise, improved coordination between nurses and SBHCs (which could be specified as standards for both programs) would also contribute to the goal of full-time health care coverage in schools.

14. What is your timeline for establishing minimum levels of services available in school-based health programs in the District?

Please see response to question 10.

15. What steps are being taken to assess the current capacity of DCPS to meet the minimum facilities requirements outlined in the [October 26, 2005] report?

DOH has provided DCPS with the results of the health suite assessment performed by CNMC in the summer of 2005. DOH has met with DCPS to discuss a timeline for conducting repairs to the health suites. DOH and DCPS will continue to meet to monitor the progress of the repairs and renovation. We expect to develop an improvement plan for all health service facilities by February 28.

16. Of the health suites and school-based health centers operating in DCPS and Public Charter Schools, how many meet the minimum facilities requirements outlined in the [October 26, 2005] report?

The survey conducted by CNMC in July 2005 shows that the health suites in the public schools and in the public charter schools covered by the nursing program received an overall rating of good or fair (i.e., facilities were in partial or minimal compliance with national standards). The areas assessed were a) physical plant, b) equipment, and c) supplies. Of the 170 schools surveyed five were found to be in poor condition and out of compliance with minimal criteria. (Please see appendix 8 for additional summary data). We have not yet performed an assessment of SBHC facilities based on national standards but expect to complete such a study within three months after submission of the proposed plan.

17. If yet to be determined, please provide a timeline for the establishment of hours of operation for school-based health centers.

In this plan we propose to study and adopt guidelines for SBHCs in place in New York State. We recommend that these centers be open and staffed during all normal school hours.

18. What role do you envision mobile health units playing in expanding access to primary care and oral health care services in schools?

Mobile health units can be used to provide a wide range of services from screenings, which are rarely performed in conventional health care settings, to comprehensive care including primary, specialty and oral services. Some experts regard mobile units as a temporary solution while primary care capacity (including school-based and school-linked health centers) expands in geographic areas where need is greatest. Others believe that gaps in established delivery systems and the presence of hard-to-reach populations will always call for the versatility of mobile units to fill those service gaps and to reach those groups where ever they live. We will propose a discussion of the role of mobile units in the context of our consultation with experts and community groups regarding viable models for school-based or school-linked health centers as medical homes.

19. What is your timeline for defining and making operational the collaboration between the school nurse and the school-based health center?

According to the timeline proposed, we plan to set standards of care for SBHC and nursing services by August 2006. The guidelines should include coordination of care between school nurses, SBHC, and other health professional staff.

20. What is your timeline for the development of policies that ensure the security and confidentiality of health records in accordance with HIPAA regulations?

We plan to complete the development of policies to ensure the security and confidentiality of health records in accordance with HIPAA regulations by October 30, 2006.

21. What is your anticipated date of completion for feasibility study regarding implementation of an electronic record system for the schools?

The IT project team plans to complete a feasibility study on implementation of shared electronic health record system for the schools by July 31, 2006.

22. How is confidentiality of records generated by the school nurse program and school-based health centers currently maintained?

Records generated by school nurses and school-based health center staff should be kept in locked file cabinets.

23. What is your timeline for the development and adoption of the student bill of rights proposed in the draft report?

We will adopt a student bill of rights by April 30, 2006.

24. When will a universal consent form for health services be implemented in DCPS and Public Charter Schools?

Drawing from the "Guidelines for School-based Health Centers" issued by the New York State Department of Health (included in Appendix 17 under section II.A 6) we propose that all parental consent forms include at a minimum the following student-related information:

- Name
- Address
- Date of birth
- Social security number
- Name of parents/guardian
- Health care coverage including, when appropriate, name of the managed care plan
- Insurance and/or Medicaid identification number
- Primary care provider's name and address, or designation of a SBHC as the primary care provider. If no health care coverage is indicated, the nurse or SBHC should assist in referring the student to Medicaid
- Authorization for release of medical information

25. The [October 26, 2006] draft report notes that there is no clearly identified person or government agency responsible for oversight of the school health program. Who within District government agencies that have a role in the implementation of school health programs will be responsible for the administrative, quality improvement, and fiscal management of school health programs?

DOH proposes that the DOH Maternal and Family Health Administration be the entity primarily responsible for the administrative, standard setting, evaluation, continuous quality improvement, and fiscal management of the school health programs.

26. How will the fiscal management and monitoring tool proposed in the [October 26, 2005] draft report differ from the tools and systems currently utilized by the DOH for sub-grantees?

The fiscal management and monitoring mechanisms proposed will not differ from District policies and procedures regarding contract and grant monitoring. DOH nonetheless plans to conduct additional site visits beyond the minimum typically required for grants and contractual agreements.

27. What is your timeline for development and implementation of Medicaid billing for school-based health services?

We expect that billing and reimbursement arrangements between Medicaid health plans and SBHC should be finalized by January 2007. Findings of the school nursing program evaluation, which will include an analysis of Medicaid reimbursement options for covered nursing services, should be available at that time as well. We will seek implementation of any third-party reimbursement option recommended in the evaluation as soon as findings become available and DOH adopts a recommendation.

28. Please outline your plan for quality assurance in the delivery of school health services, as well as the administration and oversight of the school health program.

DOH proposes that the Maternal and Family Health Administration set quality standards and manage the day-to-day oversight and administration of the school health program. We also propose that DOH take the lead in consultation with DCPS, DMH and other involved agencies in policy development.

DOH expects to set structure and process performance standards for school health center operations and nursing program practices by July 31, 2006. At a minimum, systematically evaluating the quality and effectiveness of particular school-based services entails a) reliable data collection, b) formulating interventions to improve practices and associated outcomes, and c) observing the results of implemented changes and d) learning from its consequences. We hope to complete implementation of an outcome-based quality improvement mechanism in consultation with health care providers, nursing contractor, nursing program evaluator, and experts in health care quality by January 2007.